MINUTES
HOUSE SELECT COMMITTEE ON CERTIFICATE OF NEED AND RELATED HOSPITAL ISSUES
Wednesday, February 15, 2012
9:00 A.M.
Room 421 LOB

The House Select Committee on Certificate of Need and Related Hospital Issues met on Wednesday, February 15, 2012 in Room 421 of the Legislative Office Building. Representatives Steen, Torbett, Avila, Boles, Brandon, Collins, Current, Hollo, and Randleman attended.

Representative Steen presided. Today we are going to have a quick review of some of the questions that were asked at the last meeting.

Members from the DHSR present were Drexdal Pratt, Craig Smith, Jeff Horton, Jesse Goodman, and Chris Taylor. Kip Sturgis from the Office of The Attorney General was present.

Representative Steen asked for approval of the minutes for Thursday, January 19, 2012. Minutes were unanimously accepted.

Shawn Parker, staff council, gave a presentation (see attached and on committee website) of the questions we indicated we would provide a follow up response to. He asked if Jeff Horton, Chief Operation Officer DHSR, wanted to add anything.

Jeff Horton: When the electronic database that is currently being developed for our agency is completed in 2013, we should be able to have more information.

Rep. Steen: We will now go on to the certificate of public advantage and have a briefing on this.

Shawn Parker, staff council: We were directed to cull the different recommendations that were presented. These are not intended to be vetted recommendations, so there are quite possibly are recommendations that were offered from the public, that are already existing in current law policy or practice. To the same extent, these were not intended to be your recommendations for consideration, more just topics so you can give us direction when you come back in the next month or so to take action on a committee report. It will help expedite the process, we will not be drafting legislation or working on backgrounds on things that this committee does not have interest in pursuing, so that is the intent of this. (See attached and on committee website). We did contact both larger stakeholders in this group to get clarifications on things they have presented.

Rep. Avila: Has there ever been an impartial third party study done?

Kip Sturgis: Last year we engaged an expert to give a recommendation, he came back with a report, and we made that a public process. Mission submitted its own expert report. We got a lot of public comment. It is not required by law to make that a public process but we did and we have an en depth report by a nationally known expert.

Rep. Avila: Where is that study?

Kip Sturgis: We will make it available.

Chris Taylor: Every year we have an independent CPA firm give the analysis of whether Mission's financial criteria, if they fall within the basket that is set forth in the COPA, we do annually, in addition to what Kip talked about, have an independent firm do that analysis.

Rep. Avila: Do you do any kind of performance reviews?

Drexdal Pratt: Mission is required to maintain certain certifications.

Rep. Collins: Is that designed to show whether the hospital is abiding by the terms of the COPA?

Kip Sturgis: That study was not an audit. It was an economic analysis of the competitive impact including review of the payers.

Rep. Torbett: As we go through this, I would remind committee that we have two meetings before May and that we need to starting buttoning things up and get the language prepared and get it to drafting.

Rep. Steen: We will now go through the topics for discussion. (See chart) What impact would this have?

Kip Sturgis: My understanding is that it would have no effect on Mission or Park Ridge; it would have an effect on Carolinas Healthcare Systems.

Rep. Torbett: Upon originally drafting HB 812, it listed the Hospital Authorities as a lone entity and that was not the intent. The language will probably be changed to remove any mention of public advantage. The only gest of that bill would be to remove the ten mile extra territorial jurisdiction, in the hopes this would provide better relationships between these entities and drive down litigation costs, which was the initial intent of this bill.

Shawn Parker, staff council: What this committee would want to do is to recommend concept and it would be a completely new bill draft under your current adjournment resolution would not be eligible, so whatever contents you want in it, it would be new legislation.

Rep. Avila: What type of review would there be?

Rep. Torbett: We'll get that bill to everyone and come back.

Rep. Boles: How many hospital authorities do we have?

Rep. Torbett: Five.

Rep. Avila: If they have all these abilities to engage, why are they suing each other so much?

Rep. Steen: Statutory change to ten year COPA.

Kip Sturgis: We don't have a position. Whether the COPA is terminated by ten year, at that point they are in position in having to deal with the feds in whether they are a monopoly. We are not for or against.

Rep. Steen: What happens to Mission if the COPA goes away?

Kip Sturgis: Mission acquired St. Joe's Hospital under the COPA as a means of giving it immunity from federal prosecution for forming a monopoly.

Rep. Torbett: If the COPA went away it would increase the probability of lawsuits against Mission Hospital.

Kip Sturgis: It would not have immunity, what the FTC or USDOJ would do about that, we don't know.

Rep. Steen: Do we want to take action?

Rep. Avila: We don't want to open them up to anything, if requirements or restrictions don't really apply.

Rep. Torbett: Could we ask the CEO of Mission to address this.

Ron Paulus: Our position on the COPA and its elimination really came down to how rapidly and how significantly healthcare, one only has to look at federal legislation, look at the trend and healthcare consolidation. At the time of the Copa's creation, there was only one hospital in all of Western North Carolina that was part of the system. Today there is only one hospital that is not part of the system. The competitive landscape has shifted dramatically and from our perspective, what we have requested was the option to formally terminate the COPA at such time as we believe that that was necessary and helpful to us to continue to provide and serve our mission. We're the safety net hospital for all of Western North Carolina, we have 75% plus of our patients either on Medicare/Medicaid or can't pay anything at all and it is not hard for me to envision recently likely circumstances where some of the activities we are currently constrained from and the amount of litigation that we are subjected to, the time and energy for

these kind of meetings and the distraction from the core mission of trying to improve care and make quality better and to make it more efficient. It wasn't clear to us as to what the mechanism is, should a time come when that is necessary to actually end. Our goal is not to say let's end it today, but to have a formal process where we can work with our state colleagues to unwind it at some point.

Shawn Parker, staff council: If you are the entity with a COPA, their council would be the ones to make a business decision on what might be their outcome.

Richard Vinroot: Rep. Avila, your point seemed to be that we shouldn't have an option out, because that would somehow endanger the protection that we've got. Our concern is that we've been in this thing now for 17 years. We've met every standard that has been applied to us. We're the third lowest cost hospital in this state. We're one of the 15 best service hospitals in the nation, recently so acclaimed. One of 5 in our class in the nation. We are now under this bureaucracy that the corner of Ron Paulus's office has millions of dollars of records and reports that have taken place over those 17 years and at some point this regulation needs to end. We may choose not to opt out, because of the risk that you are concerned about. It is fascinating to me that there are folks in this room that want us to stay under it for their purposes, not our purposes. What Ron said was the whole map has changed. Carolinas out of Charlotte is now in 7 locations in Western North Carolina, they are all over the place. There is competition from big hospitals out of Orlando Florida, the owner of this hospital has been picking at us for various issues. We're now in a different atmosphere. There is a day that is going to come when we say enough of this regulation, let us go out and take our chances in the marketplace like everyone else. We think that day may have come. All we are saying is give us the option. There are only 2 COPA agreements in the whole country, out of 50 states, 11 have laws and 2 have COPAs, one in Columbia, SC and one in Asheville, NC. We're not the only ones that are instep and the others are out of step. We think there out to be a provision like Montana, that lets us in some point in time say, let us out of this regulatory harassment.

Rep. Steen: If that is what this committee wanted to do, I still think there is that fear of what can happen out there from the federal standpoint.

Richard Vinroot: We have that fear worse than you do and we're not about to jump into that if we think it is something we shouldn't be doing.

Denise Gunter: I'm here this morning on behalf of Western North Carolina Community Healthcare, which is an organization of hospitals, healthcare providers and individuals from Western North Carolina with an interest in the certificate of public advantage. WNC CHI does not support termination of the COPA. I did see a draft proposal that Mission has circulated to Mr. Parker as to how they propose to terminate the COPA and we do not support that. This termination provision would require or simply allow Mission to terminate on 90 day's notice to DHSR. As I read the proposal, it did not even require Mission to notify DHSR in writing. They could simply call. There was not opportunity for DHSR to comment on that or for members of the public. I frankly don't understand why Mission would want to get out of the COPA. I have

been involved in the COPA process now along with Mr. Sturgis, their council for 17 years. I sat in the room in Asheville in August of 1995 listening to Mission and many of the other community participants talk about how badly they wanted this COPA and how badly they needed to merge with St. Joseph's Hospital. Mission has gotten everything that it wanted over the last 17 years under this COPA. They have been able to expand their footprint throughout Western North Carolina. Today they have a 90+% market share in Buncombe County. Their market share in outlying counties in Western North Carolina is in the 40's right now, if I got my numbers correct. It is growing every day. COPA has not prevented Mission from expanding or from being a very financially solid organization. I frankly don't understand why Mission would want to get out of it. The other thing that I noted in Mission's proposal for termination is that it wanted to keep the immunity that it receives, but it doesn't want the COPA. The two things do not go together. You cannot have freedom and regulation and get immunity. In response to what I heard Rep. Avila say, there is a report offered by PhD healthcare antitrust economist named Gregory Vistnes that was turned into the state around February 2011. That was an objective, unbiased review of the competition situation in Western North Carolina. Dr. Vistnes found that there are significant and serious problems and he recommended changes. When the third amended COPA was published in August of 2011, there was not record of Dr. Vistnes' report and why DHSR and the AG's office apparently dejected Dr. Vistnes' recommendations. I would suggest that if this committee is inclined to do anything, what it needs to do is first step, read the Vistnes report and then ask the question why didn't they follow this report and then after that if the committee deems it appropriate, I think what has to happen is reinvigoration of the active state supervision that is absolutely required under U.S. Supreme Court precedent in order for Mission to receive the antitrust immunity.

Rep. Avila: You referred to the constraint and to being sued.

Ron Paulus: There were a series of factual inaccuracies in the prior set of comments. Park Ridge and the Adventist system from Orlando, one of the larger health systems in the United States has for years been actively antagonistic towards Mission Health. They sued us numerous times and raise objections and concerns at each and every turn as it relates to reporting and requests for any changes. That is part of the landscape that we find ourselves in today. The constraints that we faced, to some extent, were modestly ambiguities, relates that transformation of care that I alluded to earlier. So if you look back to the time when the COPA was originally created, one of the constraints that were placed on Mission Health related to the employment of physicians. Primary care physicians were kept at 20%. At that time that was a cap like you can't spend a trillion dollars and now we overspend by a trillion dollars every year at the federal level. It didn't seem conceivable back then, but today it is. If you look nationally at physicians and whether they are employed or not, now I'm a physician, I'm not a big fan of physician employment. I really believe medicine an infection and it's a disappointment we all come as a calling, but at the end of the day that model is being transformed. It's not my choice, it's not their choice, it's the choice of the market around us and the question is how we can respond to those market changes. So the 20% cap on physician employment in primary care was something that was so out of step with the market, nationally, on average, it is approaching 70% of physicians that are employed. Those coming out of training are

overwhelmingly seeking employment and have no interest, for better or worse, in setting up their own practices. That is the kind of constraint I was referring to and the litigation has been a series of issues that relate to each and every possibility and as I was told directly by the leadership of the Adventist system that they would fund any amount of legal bills that Park Ridge desired.

Rep Avila: I'm assuming they are suing you under the possibility of issues regarding specifically to how you execute the conditioning with the COPA.

Ron Paulus: It's a mix. It's a generic set of suits. They are not specific to the COPA. It's CON, it's issues related to the concerns that they raised about our request that relaxed some of these constraints, it's the process that we are hearing today, which they haven't really originated, and so it's a constant form of harassment and it's not surprising, for example, that they have asked for a sort of competition free zone, a 10 mile radius around them to which there would be not activity, kind of like asking a running back, a defensive defender on a football field, can't actually get close enough to tackle someone, so it's a series of those issues, and unfortunately I think it describes both Park Ridge, and I can't speak for them, and us from getting about the business of transforming. It's got to be better quality; it's got to be more efficient. The fact that we were recognized as one of the top 15 health systems in America, based on mortality, complication rates, length of stay, 21% less chance of dying in our hospital. That's good, but it's not good enough. Because the people of Western North Carolina deserve to have the best there possibly can be and this is just, unfortunately, a distraction.

Rep. Avila: From somebody that doesn't live in Western North Carolina, does a hospital like Park Ridge that has slightly over a hundred beds? And you are in 90% of Buncombe and 40% in surrounding counties?

Ron Paulus: The 40% number is one of the inaccuracies in that statement. The 40% number would give blended market share, when you take the Buncombe County amounts, but when you look at the other counties, we're not typically in the 40% in those counties. Some of that is in part because some services, for example, we had 2 patients just this past week, an 85 year old and a 91 year old, who were able to receive new aortic valves without having surgery. What's referred to as the TAVI procedure, the catheter goes in through the groin and without having to open up the chest, the patients would otherwise live a completely challenged life, difficulty breathing, unable to move, they were able to receive new heart valves and go home in 3 days. We're the only organization that does that. So is it surprising we have a 100% market share of those patients? No it's not, so the market share numbers, while they are significant are inflated by the fact that it's not an equal amount of services and that reflects patient choice. When patient's drive from Henderson County, I see here today, someone who drove from Henderson County to bring his baby. So we know that people should be able to assert choice.

Rep. Avila: I understand you are doing something that nobody else is doing. What does the COPA have to do with that, limiting services that you are providing and you're the only one in

Western North Carolina, it's obvious. That's like people driving the DUKE, because there are only things that they do there. I don't understand why the COPA is so onerous that you need it.

Ron Paulus: So in part, I haven't been arguing, I'm not trying to argue that it has kept us from being successful to date. I think we have that success and I think the testament to that is in patient's exertion of choice in coming to seek services at Mission and I think it has been evidenced by numerous national and other rankings that place us in the upper decile in care nationally, but I referred to our testament, though I may not have done it well, was to say that the world is transforming and one could have argued 15 years ago, that record stores were very successful, but today digital downloads of music have transformed that model to where record stores no longer exist. That is why we are not saying end the COPA today, we're saying let's have a mechanism whereby we could end it if we face a circumstance that that would make our business plan a problem. The state in response to our request did grant some degrees of freedom on the position of relationships, so instead of 20%, that was increased to 30% and we appreciated that, it extended the 30% cap to a much broader swap of positions than just primary care, again, I would ask that relative to the national average, it's not that national averages are right, but that 30% threshold is far lower than what the normal market is. That's why we ask that over time, I can easily envision a circumstance where that might be in doubt.

Rep. Torbett: I believe I heard that there is an opt out for a 30 day notice?

Drexdal Pratt: That is in the proposed legislation.

Shawn Parker: I do have in the current record keeping that any party to a cooperative agreement who terminates an agreement shall file a notice of termination with the department within 30 days after the termination. So whether that must apply at the end of the 2 year agreement period, so perhaps it is unclear as to what the termination mechanism is.

Rep. Torbett: I would ask that we need to address that in a PED study, if there is a way to get into a process, there needs to be a way to get out of that process. It seems to me that doesn't exist with full clarity and that we address that in perhaps an evaluation.

Drexdal Pratt: Let me call your attention to a provision within the existing statute. Any person aggrieved by a decision to continue the COPA can file a petition saying, for instance, we don't want to continue, they can bring in a factual showing and through the record to show why they should be relieved of that. That is in the existing statute.

Rep. Torbett: Every 2 years there is an option in place for those entities to say we either want to stay in or get out, they have that option?

Drexdal Pratt: At a minimum, every 2 years. I'd have to look back at the statute to see is it's possible more often than that.

Rep. Steen: We're back on 812 now. What's the pleasure of the committee on HB 812?

Rep. Torbett: I'd like to address Rep. Avila's question. You were correct. The current language in 131E-20 provides may engage in healthcare activity outside boundary pursuant to and then lists 3 options and I defer to her question, is there some way we can get to the amount of litigation.

Rep. Avila: My question is, with the flexibility, why is everybody suing everybody?

Joe Lanier: We represent several hospitals who have spoken in support of this legislation. To answer your question, Rep. Avila, we believe that the key issue here is the extraterritorial jurisdiction, the 10 mile boundary extension, and that area, 10 miles outside of the county creating the authority, is where you will see most of the additional litigation. A hospital authority created inside counties that operate outside of that county as if they were in their own county. That was the issue that we were looking at.

Martha Ann McConnell: The only status if conflict in this state that is regulated by territorial jurisdiction, other than Asheville with the COPA and I'm not going to weigh in on that. Our hospital authorities, there are 4 or 5 of those in the state; Charlotte Mecklenburg Hospital Authority is one of those. If the attempt is to limit the amount of litigation, you would have to subject all hospitals to that limitation, because the only thing you are limiting is that litigation that involves hospital authorities, and really this language would regulate our ability to compete, so no other hospital in the state, other than hospital authorities are subject to the 3 regulations that you've got up there now that are going outside of the territorial boundary. Not public hospitals, not not-for-profit, and not for profits. So what you would be able to do then is the only limit the ability of a hospital authority to compete.

Rep. Steen: Is that the intent of the bill sponsor?

Rep. Torbett: That is not the intent of the bill sponsor.

Martha Ann McConnell: The hospitals that Mr. Lanier represents in Mecklenburg County, you are not limiting any competition, except for hospital authorities.

Rep. Torbett: When we are going out of the territorial jurisdiction, are all 3 of these being met?

Martha Ann McConnell: It's 1 of the three.

Joe Lanier: It is our understanding that 1 of those 3 does not have to be met in the extraterritorial jurisdiction granted by the statute. So what we are really talking about is we will compete. The hospitals that I represent and the hospitals that Martha Ann represent will compete, it is just a question of whether or not that that extra 10 mile extraterritorial jurisdiction, a public hospital authority can act as if it were in its own county.

Martha Ann McConnell: So we would not, under the proposed legislation, as I understand it to be revised, we wouldn't be able to go outside of Mecklenburg County.

Joe Lanier: Unless 1 of the 3 conditions was met. All this would do is change the territorial jurisdiction of the hospital authority.

Martha Ann McConnell: And then hospital authorities would be the only hospitals in the state that would be under that limitation.

Rep. Avila: Give me an illustration of what you sue over?

Craig Smith: The catalyst in this case was the incident in Gaston County, where Gaston Memorial Hospital proposed a satellite emergency department in Mount Holly and the same time Carolinas Medical Center proposed a satellite emergency department in Belmont, both are in the eastern part of Gaston County. This resulted in the pull of the Mount Holly proposal, the denial of the Belmont proposal and it was a contested case. The certificate has been issued to the Mount Holly facility. During the course of the initial appeal, Gaston filed a modified proposal that would address some perceived deficiencies in the original proposal. There was legislation enacted subsequent to the initial application, CMC appealed the 2nd Mount Holly proposal and that is still a contested case.

Rep. Avila: That opens up another issue that we aren't talking about today and that is one of the problems with our CON.

Rep. Boles: Do they have a facility today, is anybody being serviced.

Rep. Current: My understanding is that we won the certificate of need battle. Aren't they taking it to court?

Craig Smith: The competitive review that has been initiated in this issue and Gaston may proceed to develop the Mount Holly facility. It will take it some time to complete the facility, but it has the authority to proceed.

Rep. Current: It's more of a broader situation, when this thing first started in Mount Holly, I said what we'll end up doing is spending a lot of money on legal funds and probably end up with 2 emergency rooms, but we probably don't need either one of them. We all know it's about patients to try to come to your facility, which directly refers to money. And as I've said on many occasions, money is driving all the decisions in healthcare. It would seem to me that our job on this committee is to try and do that which is in the best interest of the quality of care of the people of North Carolina. If that involves doing away with CON and just opening the flood gates for competition at every level, so be it. That's where we need to go. In making that statement, it would seem to me that we need to determine where this group agrees with that group, where there is common ground on how we can best bring the highest quality and make it accessible to serving the needs of sick people and trying to keep them from getting sick.

Unless we are about that, we are playing games here trying to come down on one side so they can hire more doctors or whatever will bring more revenue to their system. What we've got in this country is a system out of control that nobody can afford if it continues to go up. We need to be looking for areas where we agree. In interest to the group that is opposed to doing away with this COPA, said they would prefer to see CON go away and my question to Mr. Vinroot would be do you support doing that?

Richard Vinroot: No, I don't think so. There are instances out there where you need to tell people there is room for 1 of these, not 2 of these in this geographical are. That doesn't have anything to do with what's going on with the COPA issue. What's going on with the COPA issue frankly is, a little bit like the old briar patch story. Please don't throw me in the briar patch, when in fact you really want to be in the briar patch. These folks want to keep the COPA for their own benefit. We'll run the risk of doing away with the COPA when we think we can afford to do away with the COPA. We don't need to be protected from what's happened in the past. We have been protected. We'd like to be out there to be free to compete and do the things we do in the way it's happening in the industry now, not restrained by some artificial articles on argument that was made 17 years ago about the position of whatever the issue may be.

Rep. Current: What I'm saying to you sir is what you and your hospital thinks is in their best interest may not necessarily be in the interest of the people of North Carolina and that's our job.

Richard Vinroot: I'm a believer in free enterprise and I believe that is what is great about America. A whole lot about what's going on in this COPA argument is anti-free enterprise. It's about please don't complete with us, please don't come into our territory, please draw a line around us. We ought to be about getting the best medical services to as many people as we can and not draw a line to keep those services away from those people. Interestingly enough, the Vistnes report was mentioned. It made no analysis about that we were meeting our responsibilities under the COPA rules. Another report by Dr. McCarthy came in and answered all those questions and said this hospital has consistently for 17 done all the things we were supposed to do. Are we going to regulate this system for another 17 years, because somebody doesn't want competition anywhere near them? That's wrong.

Barbara Riley: I thought I heard Dr. Current say that this group supports abolition of certificate of need and is not correct.

Rep. Torbett: I want to get with the friends that spoke on 812 and bring that back to committee at a later date.

Rep. Steen: I would ask that you get with Rep. Torbett and try to work this 812 out; I think there is some common ground we can get to. COPA modification oversight. Standard measures of empirical data direct the rule making, time other state resources. Rep. Torbett you pointed out the fact that we may could send this to a study through the PED program, would you like to speak on that?

Rep Torbett: Perhaps we need a fresh look at it.

Rep. Steen: Wishes of committee? We need to get communication at federal level to see what happens when we do come out of this COPA.

Rep. Avila: Has anybody from Mission talked with DOJ or spoke with federal in terms of how they review change?

Kip Sturgis: We work with the DOJ on a number of things; I have alerted their people this may be coming down the pipe.

Rep. Steen: The annual or semi-annual review of changes to public review. Wishes of the committee?

Rep. Torbett: I believe the intent of this was to have an unbiased independent agency do an audit every year. Ron, does Mission provide its own audit to DHSR or do they do an independent audit?

Craig Smith: They provide a report to us. They prepare the periodic report. That's not subject to the separate independent audit as is done on financial material.

Rep. Torbett: Every 2 years there is an independent financial audit taken and the collection of that data are not brought to you by Mission?

Craig Smith: There are 2 reports. The periodic report is done every 2 years and Mission prepares and we sit down and have discussion. Every year Dixon-Hughes, an independent CPA firm does annual work for us based on a basket of hospitals which we have selected that are hospitals we have determined to be similar to Mission. They get financial information from their audits and their cost reports and determine if Mission is falling within the parameters of the financial criteria in the COPA. Dixon-Hughes does that for the department. We selected them. Mission pays for it. It is done at our direction and under our control and while I do have the floor, the item about an additional audit, if it is the desire of this committee to have that done, I would suggest that it would be more efficient to employ Dixon-Hughes to do that work. They do financial and operational audits for more hospitals than any other.

Rep. Torbett: So if they did 1 audit, you are suggesting they do the 2nd audit too?

Craig Smith: Yes.

Rep. Torbett: What would they be auditing the 2nd time?

Craig Smith: They would be auditing the criteria such as the percentage of physicians that are employed. There seems to be a question.

Rep. Torbett: Currently that information is brought to you every 2 years by Mission. So they would audit the non-financial data?

Craig Smith: They would do a compliance audit.

Rep. Avila: Has there ever been an independent audit?

Craig Smith: There has not been a separate independent compliance audit. That information is provided to us by Mission and we have had no reason to doubt that they were providing us correct information.

Rep. Torbett: Would that reduce the paperwork they have to go through every 2 years?

Ann Young: We do file a report on an annual basis. One year is called an annual report and the next year it is called a periodic report, but the content is essentially the same and on an annual basis, Dixon-Hughes provides the audit of compliance with the various financial parameters of the COPA.

Richard Vinroot: Will the 2nd audit cost more money? You are dern right and the question ought to be who ought to pay for that? I don't suggest the state does it; I don't suggest we do it. If somebody else wants to come in and do a separate audit, fine, have at it, but you pay for it, don't ask us to keep paying millions of dollars for all of this.

Rep. Torbett: My concern was that it maybe helps you cost less for the paperwork that you currently do. If you are performing that audit internally now, that has to come at some kind of cost and if you didn't need to do that audit because someone was doing that audit.

Richard Vinroot: We are required to under the current COPA. That is why we are doing it.

Rep. Boles: The audit that is required is both financial and compliance?

Jeff Horton: The statute doesn't use the word audit; the statute uses the work review. The work that is done by Dixon-Hughes for us we consider it's actually an agreed upon procedure from what we have said, we want you to look at A, B, C, and D.

Rep. Boles: They are only reporting one, based on an audit that they pay for and does it have both the financial and compliance component? Are both required by the general statute?

Jeff Horton: We made the decision to have an independent firm do the work as to whether or not they met the criteria, because we do not have the resources to do it ourselves and that was something which was agreed on by Mission in working to expedite the process.

Rep. Boles: But the 2nd component, the compliance, is it statutory that it be audited?

Jeff Horton: No, it says that you will review it.

Rep. Steen: Please of committee?

Rep. Avila: Considering there is so much at stake, in terms of government transparency and what's going on and all this other stuff, a financial audit says you are not embezzling money and you are spending it the right way. It doesn't say whether you are spending it on the right things and how it is being done. I think that with COPA, that is one of the issues we've got to determine in what they are doing and how they are doing it. I don't think we can recommend because we don't know enough in terms of is it, has it worked the way it is, can you modify it, is it archaic?

Rep. Steen: So would you like to see a more in depth or annual report or every 2 years?

Rep. Avila: I've questioned a lot of people out there about what's been done the last 17 years and I think get it cleared up, so with this transformation of medical care taking place, and then we can use under this direction or is there something different that we need to pursue.

Rep. Steen: Is this a consensus? Is there anybody opposed to this?

Rep. Avila: We need a more in depth financial audit. Also a PED study about what a COPA is in the state of North Carolina.

Rep. Steen: So we'll send this to PED if this is something we can do as a study committee. COPA modification activities, it mentions a moratorium on projects, the committee action would be non-codified and there may be some constitutional limits on this. Does anyone want to see us go forward with that? Shawn, you may want to discuss that.

Shawn Parker: This committee probably could not direct the PED study; we could recommend legislation to direct the PED study. As Rep. Avila brought up at the end of the last meeting. I just would very broadly speak to concerns that anytime you have government taking a retroactive impairment of a current contract. By all bounds of the constitution, when you are directing actions towards a contract that would already be in place, the general assembly as enacted moratoriums on activities, in that same sense, I would advise as your council, that you leave that moratorium to a broad class, you would not want to individualize a moratorium directed at a specific entity.

Rep. Steen: I don't see anyone saying we need to go in that direction. Restrictions on activity for COPA recipients.

Shawn Parker: The proponents of that measure, they can go into a little more detail on what specific activity restrictions. Again with the earlier round, if it would broadly apply to any party to a COPA, you would have more leeway than trying to assert that to a current COPA, with the

exception, just on the reporting process, there could be direction as part of the department's purview on what this general assembly would believe as appropriate. For those who brought this up, if they could say which activities or what type of restrictions, I think they would be better suited to speak.

Rep. Avila: Are there things that can take place, that at some point in time, we do things that some of the issues get settled, that something can be done that we can't undo and it totally defeat the purpose.

Rep. Steen: We do not want to do any damage to anyone.

Graham Fields: What you are seeing is acceleration on the part of the only entity in North Carolina operating under a COPA. I think there is a recognition and understanding this committee is getting to the bottom of some of their activities and as this information begins to come out, it is clear that there is an acceleration on their part with aggressive projects and projects that probably wouldn't get any new standards with this discussion, so I believe that that is the effort to sort of footlight them, that just as you said, these projects will be done, they will have all the agreements and essentially by the time anything comes out and we find out, it will be too late for those types of projects and the big thing is, the patients will be effected. My question to you would be if there is a way; at least until the study is complete, to just pause things.

Richard Vinroot: This is strike 3. These folks don't like a joint venture project between the party of the largest hospital in Henderson County and our hospital on the county line. So they asked these folks 2 years ago to stop that project. They said there is no basis for that. They then had a representative, who incidentally is a member of the Adventist Church in the Senate, to submit a bill that would have stopped the project. The bill went nowhere. Now this is the 3rd effort. We want you in this process to somehow stop that project. This is not about free enterprise, this is about stopping competition between another 2 hospitals creating an inpatient facility, beg your pardon, just the reverse, an outpatient facility that they think is too close to their facility. That's what this is. An extra effort to try to get your committee to get into the CON process.

Rep. Avila: Under the circumstances, if Mission is doing what they are supposed to be doing and in the interest of medicine and everything and there is no problem at pausing to getting all the truth on the table. If your provision is what it is it would prove out one way or the other? You've got nothing to lose.

Rep. Steen: Any projects that are being done are these projects that would be happening anyway, if they weren't under the COPA in your opinion.

Graham Fields: I believe that they are only possible because of the protection afforded to market position under that, they are only possible. Just as a point, they are not finished, there's

no building, there's nothing there and frankly the CON itself for the first part of that project was denied by the state.

Rep. Avila: Goes back to Shawn in the terms of what we legally can do.

Rep. Boles: As far as the moratorium, this process still has to go before a CON committee?

Craig Smith: The project is a medical office building and does not have to go before CON. If there are other proponents to go into this building that fall under CON, they would have to submitted and reviewed.

Shawn Parker: I would fall back to my general interprets on concerns, it will be fact specific, you are speaking to this one individual circumstance and that is how the committee requests the draft. I could do a better analysis based on how much of a restriction or what type of moratorium to do, that's the type of direction I would need. But in general, I would caution just the concern of when you speak to doing a moratorium or restriction on activity.

Rep. Avila: You said that there is some operation in this particular facility, are there any that would not require a CON based on any benefits. That there would be a way to get the footing for this?

Craig Smith: They are working on a medical office building. Unless the project is subject to a CON law such as an endoscopy, they have discussed with us a satellite emergency department, anything of that nature, which would require a CON.

Chris Taylor: The facility that Mission is proposing, that is not part of the COPA.

Ron Paulus: I just want to emphasize a couple of points that I think that have been distorted. This building project, literally, has nothing in any way, shape, or form to do with COPA. Except that in the extent that those representing the Adventist and Park Ridge would like to bundle that somehow to confuse the issue and distract from what the actual activities are. I can think of no reason that makes any sense, whatsoever, that whatever this committee chooses or not chooses to do in its wisdom, auditing or what have you in respect to that, why it would relate to anything completely and independent and separate from the COPA and specifically to which there is not CON requirements of any kind. That to me is just part of the whole interesting phenomenon that we have. The second thing is on the proposal to doing an extra audit. Just to be clear, it's not as if, we have reported every year for 17 years and it has always been audited from an outside entity, Dixon-Hughes, supervised and selected by the state, paid for by us, we've paid for a lot of those things and the whole purpose of the COPA was to try to create protection and ensure that the merger would not create anti-competitive pricing. That's what those audits are all about. The other components, in terms of conformance with the percentage of physicians employed, etc., etc., those were additional compliance restrictions and we've provided the information and can attest to that as well. I just want to make sure the committee understands, it's not like we haven't been audited or reviewed over the course of 17

years, in fact, we have been audited and reviewed every single year by an independent separate certified public accountant firm that does the most of those audits in any such firm in all of North Carolina.

Graham Fields: This project is estimated from 80 to 130,000 square feet. We've heard a variety from outpatient surgery to ER, so forth, for a medical office building 4 miles from a hospital in a community of about 6,500 people. So I guess the question is, is this project is in the spirit of the COPA. It's interesting in the Vistnes report that monopolies are mentioned. It is amazing that that report is not implementing, discussed, and even talked about.

Rep. Torbett: I want to ask when a COPA is developed and you are working on the guidelines, does it dictate that it has to be within a geographical or territorial boundary or can it be described as the entity with no boundaries?

Kip Sturgis: I think the law allows for both possibilities, typically yielding to the reality of the situation, county lines don't define the geographic area in which a business operates, whether it's a car dealership or whatever, they are going to draw people from all over. So I think to say within this particular geographic area you should or shouldn't do whatever, I think that is artificial at this time.

Rep. Torbett: COPA is based more on the entity acquiring the COPA than any territorial lines?

Kip Sturgis: I think that's the way an economist would view a competitor's position in the marketplace, you look at their own geographic market area, however, and that is defined. It's not specifically being city lines or county lines; it's going to be where they draw their customers from.

Dr. T.J. Pulliam: I am the lone G.I. doctor for Wilkes County, currently serving as the vice-chair of the SHCC and personally I absolutely appreciate the time, energy, and efforts that all of you are putting into this process. We have to continue to look and relook at we are doing here in North Carolina when it comes down to healthcare. We are a state that is resource rich in healthcare. Rep. Current is absolutely right, there is a lot of money out there and a lot of what comes before the SHCC, we are trying to make sense of how to distribute healthcare around the state with an eye on quality, access, and value. As far as this whole COPA thing, I didn't know much about it and I've come here to try to understand about it and I think the more I've learned, the less I really know. The one thing that I would suggest is "first do no harm". I appreciate the folks that have tried to bring the discussion back around to the patient's concern, because ultimately that is what this is all about. That's why I drive to Raleigh several times a year; the thing that I think is relevant today is that Mission is able to keep their doors open serving 75% of patients with government payers. I want to know how you are doing that, because as we move ahead in healthcare reform, every hospital in the state is going to be overwhelmed with government payer patients. The best news is this: all of you doing this important work, all of those who sit at the table of the state health coordinating council, are all well intentioned people.

Rep. Collins: What is the recommendation to authorizing the COPA recipient to terminate the agreement 10 years after?

Rep. Steen: We are going to put into PED study or study further.

Rep. Current: All of that was cleared up in Mount Holly?

Jeff Horton: They are building that. No one has filed a CON to develop a second satellite ED.

Rep. Steen: We do have the Vistnes report and the McCarthy report. They will make that available electronically to all the committee members. The COPA is a very complex issue as our folks on the committee can attest. The more we learn the more confused we do get. We do not want to do any harm, so doctor I appreciate you bringing that up. Did the COPA give one side too much advantage or has it restricted them as it's progressed to today's time. We are trying to get to the bottom of and we are trying to do it objectively and we are in the middle and we appreciate all the comments we heard today. Our biggest concern is if COPA goes away, what will the feds do? As we send this to PED, we'll have some other follow up later on COPA. Rep. Steen adjourned the meeting at 11:45 a.m.

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Representative Fred Steen, presiding chair Viddia Torbett, committee clerk

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Representative John Torbett, co-chair